May 4, 2009

Managed Care Organization/RSN All Plan Meeting

9:30 – 2:30pm

Why are we here? Business is different than other DSHS providers, but RSNs and MCOs have a lot in common (e.g. 820s, 834s, etc). This afternoon we will break out into MCO and RSN specifc groups to answer the specific questions for each group.

Todd Emans:

- 3 different phases of testing.
    - 837 – EDI 1 – Interaction with the system at the file level – is file valid? Tests for format compliance – HIPAA error levels 1, 2, and 7. 1 & 2 are syntax and format on the file.
    - EDI 2 – beyond file format – looking at how you do business with us. Is the system editing correctly, etc. Now that we have the file, how valid is the information in the file?
    - 834 enrollment roster and 820 premium payment – This is a test to ensure MCO/RSN can handoff the file. It's the ability of your system to handle the files.
- Submit using SFTP. May be a little different than it's done today. RSNs maybe not so different than today. MCOs have schedules to submit. In the future, automated and daily jobs will be running. 2 sets of folders on SFTP site – test side and production side. This SFTP site is different than the one we have today. To pass EDI 1 testing, we need a positive TA1 and positive 997. Then we translate file and load it into our system. ETRR is encounter transaction results report. This is the file that deals with the business edits.

Q: What is the HIPAA error folder? On inbound transactions if the file has errors in the file; any file that isn't compliant will be dropped into an error folder. There is a negative acknowledgement indicating that something was wrong with the file and it was not accepted.

- TA1 is like an envelope – if the address is wrong on an envelope we don't even open it. The 997 is the letter within the envelope that we look at in more detail and it either passes or there's an error in the file format and it fails. Positive TA1 and positive 997 is the evidence of successful testing.
- The custom report is a user-friendly representation of the 997. It can tell you where an error occurred.
- Through testing MCOs/RSNs will submit an encounter file. It will either have a positive or negative TA1. If positive TA1, the 997 follows. If the 997 is negative it errors out and the MCOs/RSNs fix the errors and resubmit. Both need to be positive.

Q: When MCOs are submitting files is that expected be on a daily, weekly or monthly basis? The system can receive files as often as daily. It's a business decision.

Q: What's the level of checking you are doing on your outbound files? HIPAA edits to 7 levels. DSHS made the decision to monitor levels 1, 2, and 7. We have adjudicated edits in place to take care of some of these steps. Outbound files are held to the same parameters at inbound.

Q: Do TA1, 997, etc use the same set of error codes? ETRR is our internal edit codes so they wouldn't be on the TA1 or 997. The 997 and custom report is a mirror of one another. The TA1 and the 997 use the same

HIPAA codes. The codes are obscure because you have to do the leg work to figure out what the error is. The custom report will assist you to pin down where the error is.

Q: In the system processing will there be another report with the errors on it? Yes, that's the ETRR and that will show you where those errors are. Business edits are in the ETRR. The TA1, 997 and custom report deal with file construction. The ETRR is the business remittance and results of our acceptance and edits checks.

Q: When we get a file, how long do we have to give an acknowledgement? By contract acknowledgments must be available within 24 hours of submittal, but it's been pretty automatic in testing. There are differences between ETRR responses – they are set up on a weekly run, but it is also based on your business times. If you submit monthly, you won't get a weekly file.

Q: MHD has a limit on how much we can send in a batch, do you? Yes, HIPAA recommends not having more than 5,000 claims within a single functional group. In the campanion guides there is info on file size limitations. P1 has an interactive web portal with a 50 MB file size limit and the SFTP has a 100MB limit.

Q: If there's an error in the file based on business rules; where will that appear? On the ETRR file. **Is there a lag time?** Yes, ETRRs are created and delivered on a schedule so it depends on what you submitted within the catch period. It will be rare to have dispositions on half a file. If we capture it, we'll capture the whole thing. ETRR takes it down to the level of the encounter itself.

Q: Is the patient account number more like the claim number? Yes, the patient account number is the "claim number" for the submitter's system.

Agnes Ericson:

Prerequisits for testing:

We have provided companion guides. You need to be able to modify your system according to the companion guides we've distributed. These guides need to be used with the HIPAA guide. These are all available on our HIPAA website.

Q: Guides are being updated and new versions will be distributed. In the clarification will it be redline stikeout? In the change table it shows you what has changed. The updates to the guides are just changes that enhance the guides; you can code to the current guide. There will be no redlining strikeout changes in the revised guide.

Q: You haven't mentioned pharmacy? The pharmacy companion guide is out on the website. We will not discuss pharmacy practices today.

FYI - There is a listserv for general provider communication. Additionally DSHS will deliver customized messages to the MCOs and RSNs.

You should use our companion guides and modify your systems accordingly to comply.

The P1 Client ID is new. We used to have the PIC. Now the P1 ID takes its place. The system will assign a unique client identifier. This P1 ID will stay with the client for the client's life – no matter if they go on and off services. No new P1 ID will be assigned. They will also have a card with that number on it. You will need a crosswalk from PIC to P1 ID. We have developed a crosswalk which is available on our website. You will use

your current 7 digit Medicaid ID number to access the PICs that are part of your network. RSNs will be able to pick up their P1 IDs from their current SFTP site. MHD is working to get a little more detail on the site to identify clients. The MCO site uses capitation payment history from your plan's ID.

Q: RSNs get more than a capitation payment per client. I currently may get more than those with IDs**. The 834 would have less for the RSNs than they do today?** Yes, the 834 will only have clients enrolled in our P1 system.

You cannot test with a PIC. You must use an actual P1 Client ID.

Q: Is it just a 12-month history of claims on the crosswalk? No, it's two years of history.

30 days prior to go live, you will need to download a new revised crosswalk before actual go-live.

Q: When are you recommending that the Client ID be in our production system; prior to our first 834? Get the crosswalking done starting 30 days prior to go live when it is available.

Most servicing providers need an NPI. MCOs and RSNs will identify themselves using a Provider One Provider ID.

We also need the taxonomy of the pay-to provider. This is something that's in the companion guide.

Q: So it's not on the rendering provider, just on the pay- to provider? No, just the pay-to provider.

Billing provider is the MCO or RSN. Pay-to provider is the actual servicing provider.

Q: The service provider's NPIs – is there a registration of service providers with the state? HIPAA validation will just verify that it's a valid NPI. There are reporting levels for RSNs. Please refer to the companion guides for instructions regarding the submittal of rendering providers for RSN submitted encounters. At a high level, we will not report beliw the CMHA for 837P MH encounters and we will not report below the E&T Center for 837I encounters.

You must have security for the P1 secure transfer protocol.

The SFTP: This is the site where MCOs will be submitting encounters and retrieving files.

A TPA is also required for registration.

Q: Is there multiple user IDs for multiple users or is there one entitiy wide? One entity wide ID.

In order to test by May 26th, your systems must be able to coordinate with our system using the companion guides.

Sally Brennand:

Provider One security – SFTP site interacts with P1 and brings you back your transactions. There will also be a web portal available. 60 days prior to go-live there will be training on web portal use. Using the web portal, you can look up client eligibility and you can look at a batch of 270s.

You will have to do security set-up to access the web portal. Everyone sets up a system administrator. The profile "providerone managed care onl" will give you all the access that is available. If you have staff that don't need all that access, there are lesser profiles that allow just eligibility verificaiton, etc.

The same website that gets you the PIC crosswalk will get you the security steps as well.

Q: Is there something in the upload and download to show you what access you have or if we assign that, do you get everything? Yes, you get everything.

Chris Brown:

User Training:

If you need a refresher, you can go online to view the security requirements on our website. There are tutorials and a Registration and Security Administration Guide available and there will be more security webinars coming up.

Go-live training will occur 1-2 months prior to implementation. It will be a combination of Webinars, Tutorials, and a ProviderOne Provider System User Manual.

You can attend Webinars from your desk. You will be given a website where you register for Webinars. There is a question and answer functionality in a Webinar. There is another form of Webinar that is like E-learning. E-learning is a self-paced learning tool. You can take an E-learning course from your desk at a time that is most convenient for you. There is no question and answer functionality with E-learning however the information taught is the same as in the Webinars.

We are trying to get trainings scheduled as closely to go live date as possible.

Prior auth for RSNs will be a separate webinar.

Q: Will you be posting a calendar of those? Yes, we will be notifying you when the training schedule is posted.

Q: Do MCOs have to input patient auths into P1? No, MCOs have their own claims processing system that they use to pay.

MCO AFTERNOON SESSION

MCO BREAKOUT SESSION:

Q: How many characters will the Provider One ID have? 9 numbers followed by 2 letters "WA".

RAC is a new code that takes the place of the program, match, and eligibility codes. The RAC is 4 digits long and will be sent in the 834 transaction.

Q: So the RAC will help us identify S women? Yes. RACs identify different categories of eligibility.

Another important change: The ProviderOne ID numbers are a 7 digit number that identifies the MCO and then 2 characters that identify your line of business.

Q: Is that linked to the member record? Yes, because the client is enrolled in that program so you'll get a list of clients on your 834 and 820 with that number identiying the line of business.

Q: What about when the new over 300% program comes in? If it's a brand new program, we'd add a new extension number to indicate a new line of business.

Q: Will all the records be combined together or will there be a file for each line of business? There will be individual files for each line of business. You will be able to tell the line of business of each file because the suffix will be specific on the file name.

Q: So there will be a different number for healthy options/blue shield or blue shield/s-chip, whereas now we only have one number? Yes, you will have a specific number for each line of business.

Q: Will eligibility be adjusted on the 834 weekly change files and show up on the 820? We will be sending out an 834 update file that will come out every Monday. That file is for adds, changes, and terminations. So yes, you may see your retro newborns or adjustments (e.g. SSI babies) on the weekly 834. Then at the end of the month, we have a cuttoff that is the 5th working day from the end of the month and the next day you will receive the 834 working file which is a roll up of all the clients we'll pay a premium for.

This system allows us to make sure the client is eligible up to the last working day of the month so on the last working day of the month, we will send out one last update that will show anyone who lost eligibility or manually decides to enroll. You will get more 834 updates than what you normally get.

You will have a more final file this way at the end of the month and we will be able to get more people in more quickly.

The clients however, must receive ten days notice of a change before the main cuttoff (which is 4 days before the end of the month)

Can you send out an email with the cuttoff dates on it? Diagram posted with these notes.

Q: We will still have clients who may not be enrolled until the following month if they miss the cuttoff? Yes.

FYI - We will still generate one payment a month, but we have the capability to do a daily payment or a weekly payment.

If you make the changes to do retro we need to know that. Yes, we won't do that without discussion with the MCOs.

When we implement P1, the MMIS system is going away. When we test with the 834 and 820 you will have to give us feedback about how it is working. One of the biggest changes with the P1 system is the DCR. Currently we accept a claim to tell us that an MCO client has given birth and we've been processing that as a claim. In the future that will no longer be the case. Make sure your business is ready to submit those encounters in order to get paid for your DCRs.

Q: FQHCs and RHCs will get their enhancement from MCO encounter data reporting. **Where do we put the NPI number on the file?** This information is in the companion guide. There is a separate taxonomy for the FQHC/RHC. So you will report the NPI and the taxonomy. We need to make sure that the MCOs are coordinating with the FQHC/RHC. The NPI with the taxonomy suffix must match on the encounter data in order to generate the enhancement to the correct FQHC/RHC.

There are rules built for accounting for full risk clinics, etc.

Q: Do FQHC/RHCs only have one NPI? Not necessarily. We are trying to get the word out though that FQHCs/RHCs will report the NPI that that clinic intends to bill for their deliveries because that is the NPI that will be on their encounter. FQHC/RHC should be submitting a bill with the NPI on it. For regular PM/PM business, FQHC/RHCs are billing the MCOs so they should be using their NPI number w/ taxonomy so that MCOs can pass the number on to DSHS. MCOs need to load and use their NPI related to their FQHC/RHC business.

Q: Some providers have no taxonomy that applies to their specialty. What do we do with those? There is an NPI that says they're a hospital but they are billing for professional services. **Will this be a problem?** We will probably have this and other problems based on the fact that providers were responsible for following federal NPI/taxonomy regs and did so using their own discretion.

Q: Will DSHS have any edits on whether or not that taxonomy matches what the provider's business is? No, except the FQHC/RHCs must have their NPI and taxonomy code that idetifies them in the pay-to provider field as an FQHC/RHC.

Q: Is the provider to submit the taxonomy code on the claim or do MCOs add it? Q to MCOs: Do you not require the taxonomy now? If you pay it using the wrong taxonomy and you report it on your encounter, we will not report it as an FQHC/RHC encounter.

Agnes showed group format of FQHC/RHC rosters that MCOs must use.

Q: What if it's a retro payment? There are codes: Normal and reverse. Normal could be a back date.

Q: Could there be one record per month or can it be 6 mos of records? You could export CSV to Excel. Typically it's one month at a time, but we don't know if it's possible to do more than that.

Q: Will the system accept CSV, or just Excel? Excel is the program of choice. And it needs to be native Excel.

Q: What response would we get back if we sent the wrong format? You will get a worker email or phone call not an automated systems response.

Q: Will there be testing on FQHC/RHC formats and acceptance? DSHS is discussing this now.

Q: How are retro newborn payments generated? When we receive the newborn info from ACES, the baby will be enrolled and mom's client ID will be on baby's record and the payment will be made on the next 820. You will enroll the baby at the time it comes on the 834. First 21 days of baby's life is the retro newborn period.

Q: How should we notify you if the mom does not enroll the baby? The billing instructions spell this out showing an excel sheet for communications of recoups or other business. We are working out a way on an online application to have a click box for newborns so we will ask a few questions and when you're finished you can send it into ACES automatically. Health plans, providers, hospitals, etc can do this directly. No signature is required and the mom doesn't have to give permission.

Q: What if someone gives the wrong newborn info? There are processes to deal with that.

Q: Will the online option be ready with implementation? You can use the telephone today using the statewide call center number, but the online application is being created.

The baby's gender is really important because P1 needs it to pay. The Hey Mom form has the required information on it.

Q: In the 834, the rate region code is missing from some of Molina's data. Can DSHS assist with this? Molina will email Agnes and she will look into it.

Agnes handed out an 834 sample.

Encounter data:

Q: When will you have the draft of the encounter data guide out? It should be out hopefully by the middle of this month (May). You can report encounter data weekly and the payments will also come on a weekly basis for those encounters.

Q: Will there be scheduling conflicts? DSHS used to not want encounter reporting done by multiple plans on the same day. No, with P1, there will be no conflict. The system automatically grabs files that are there and processes them. **Can the system handle that load?** Yes, but that's what we're testing for.

The test system that we are having available from 5/26 to 8/11; any data that's put into there will be scrubbed after testing so no data will be kept in the test environment.

Q: Where do I submit my test data? The encounter data guide has specifics about the URL where you submit your test data.

Q: Will the NCPDP follow a different timeline? We have tested current NCPDP files in the current system and we're still working on getting that system up and running. It won't follow the regular testing process.

Q: If we go live w/ P1, we can just hold on to NCPDP data until it's ready to go live? Yes, you can wait for it if it's not up and running by go-live.

MCOs should very specifically follow the mapping process step-by-step. It must be in the same order otherwise your file may not be accepted.

So MCOs are to continue to submit info on the old pharmacy site until DSHS tells us to start using the new pharmacy system? Yes.

Q: If we have data that we need to make corrections on, can we wait to make those corrections after go-live or do we need to make them all now? You can wait to correct the data but you must use the provider one format when you re-submit. There is an explanation in the guide.

Q: Will we still get a monthly provider file? No, you can get it online on the national database unless you have atypical providers. The IPND is no longer available.

Q: Is there parallel testing in the old system and in the new system? No, you will receive files and we will receive the 837 and make sure it passes.

The managed care testing will mimick a full testing month's cycle. It will follow the real schedule.

Q: Is the HCA roster file still being generated? Yes, you will continue to get the roster from HCA.

End of Meeting